OMNICARE HEALTH PLAN

Statutory Financial Statements

December 31, 2001 and 2000

(With Independent Auditors' Report Thereon)

OMNICARE HEALTH PLAN

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KPMG

Suite 1200
150 West Jefferson
Detroit, MI 48226-4429

Independent Auditors' Report

The Board of Trustees
OmniCare Health Plan:

We have audited the accompanying statutory statements of admitted assets, liabilities, and capital and surplus of OmniCare Health Plan (Plan) as of December 31, 2001 and 2000, and the related statutory statements of revenue and expenses and changes to capital and surplus, and cash flows for the years then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described more fully in note 1(b) to the financial statements, the Company prepared these financial statements using accounting practices prescribed or permitted by the Insurance Department of the State of Michigan, Office of Financial and Insurance Services (OFIS), which practices differ from accounting principles generally accepted in the United States of America. The effects on the financial statements of the variances between the statutory basis of accounting and accounting principles generally accepted in the United States of America also are described in note 1(b).

The accompanying financial statements have been prepared assuming that the Plan will continue as a going concern. As discussed in notes 1(a) and 2 to the financial statements, OFIS has placed the Plan into rehabilitation status as of July 30, 2001. The Commissioner of OFIS, acting as Rehabilitator (Commissioner), has filed a comprehensive financial plan with the Ingham County Circuit Court (Court) outlining its plans for attaining the required levels of regulatory capital. The Commissioner has not received notification from the Court that its comprehensive financial plan has been accepted. Failure to meet the capital requirements and interim capital targets included in the Plan's comprehensive financial plan would expose the Plan to regulatory sanctions that may include restrictions on operations and growth, mandatory asset dispositions, and placing the Plan under increased regulatory control, including potential liquidation. These matters raise substantial doubt about the ability of the Plan to continue as a going concern. The ability of the Plan to continue as a going concern is dependent on many factors, including ultimate execution of the Commissioner's comprehensive financial plan. The Commissioner's plans in regard to these matters are described in notes 2 and 9 to the financial statements. The accompanying financial statements do not include any adjustments that might result from the outcome of this uncertainty.

In our report dated May 18, 2001, we stated that we were unable to express an opinion on the 2000 financial statements as it was not practical to extend our auditing procedures sufficiently to satisfy ourselves as to the fairness of the assumptions used in determining medical claims liability as of December 31, 2000. As described in note 3, the Plan has revised its assumptions used in determining medical claims liability and restated its 2000 financial statements pursuant to a permitted practice from OFIS.

Because of the significance of the uncertainty discussed in paragraph 4, we are unable to express, and we do not express, an opinion on the accompanying 2001 and 2000 financial statements.

KPMG LLP

March 15, 2002

OMNICARE HEALTH PLAN

Statutory Statements of Admitted Assets, Liabilities,
and Capital and Surplus

December 31, 2001 and 2000

(In thousands)

Assets		2001	2000 (Restated)
Current assets:			
Cash and cash equivalents	$	24,666	3,714
Short-term investments		52	49
Total cash and short-term investments		24,718	3,763
Accounts receivable:			
Premiums		2,392	2,552
Health care receivables		5,077	9,050
Other		220	450
		7,689	12,052
Due from affiliate		2,988	385
Investment income due and accrued		19	16
Total current assets		35,414	16,216
Marketable securities		1,154	1,082
Other long-term invested assets		399	358
Total assets	$	36,967	17,656
Liabilities and Net Deficit			
Current liabilities:			
Medical claims payable	$	89,468	55,642
Capitation withhold and referral risk pool		1,957	1,477
Total medical liabilities		91,425	57,119
Claims adjustment expenses		519	—
Accounts payable and accrued expenses		511	22
Due to affiliate		—	888
Total current liabilities		92,455	58,029
Accrued liability		2,343	344
Total liabilities		94,798	58,373
Net worth (deficit):			
Surplus notes		17,300	17,300
Net deficit		(75,131)	(58,017)
Total net deficit		(57,831)	(40,717)

OMNICARE HEALTH PLAN

Statutory Statements of Revenues and Expenses
and Changes to Capital and Surplus

Years ended December 31, 2001 and 2000

(In thousands)

		2001	2000 (Restated)
Revenues:			
Direct subscriber and commercial premiums earned	$	50,097	55,010
Medicaid capitation		142,673	115,737
Other health care-related revenue		198	1,944
Net investment income		498	617
Total revenues		193,466	173,308
Operating expenses:			
Medical services:			
Inpatient		63,683	46,364
Outpatient		24,380	24,475
Emergency room and out-of-area		11,842	13,935
Physician services – primary care		21,229	20,318
Physician services – specialty care		28,435	16,186
Pharmacy		26,717	27,172
Other professional services		13,290	18,055
Reinsurance		375	532
Total medical services		189,951	167,037
Management fee		20,021	18,691
Claims adjustment expense		519	—
Bad debt expense		—	2,951
Other administrative expenses		439	631
Total administrative expenses		20,979	22,273
Total operating expenses		210,930	189,310
Change in net deficit		(17,464)	(16,002)
Net deficit – beginning of year		(40,717)	(7,576)
Prior-period adjustment		—	(29,489)
Adjusted net deficit – beginning of year		(40,717)	(37,065)
Issuance of surplus notes		—	12,700
Change in nonadmitted assets		350	(350)
Net deficit – end of year	$	(57,831)	(40,717)

See accompanying notes to statutory financial statements.

OMNICARE HEALTH PLAN

Statutory Statements of Cash Flows

Years ended December 31, 2001 and 2000

(In thousands)

		2001	2000 (Restated)
Operating activities:			
Premiums and revenues collected	$	194,241	169,470
Claims and claims adjustment expenses		(155,645)	(158,702)
General and administrative expenses		(22,696)	(19,966)
Other underwriting income		4,660	5,922
Cash provided from (used in) underwriting		20,560	(3,276)
Net investment income		458	530
Other income		8	—
Net cash provided from (used in) operating activities		21,026	(2,746)
Investing activities:			
Cost of investments acquired		(504)	(754)
Proceeds from investments sold		433	431
Cash used in investing activities		(71)	(323)
Financing activities:			
Issuance of surplus note		—	4,000
Net change in cash and short-term investments		20,955	931
Cash and short-term investments at beginning of year		3,763	2,832
Cash and short-term investments at end of year	$	24,718	3,763

See accompanying notes to statutory financial statements.

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

OmniCare Health Plan (the Plan) is a federally qualified, not-for-profit organization formed for the purpose of promoting and operating a health maintenance organization (HMO). As of December 2001, the Plan was providing health care services to approximately 95,300 covered members, primarily in Southeastern Michigan. The provider network for the Plan consists of 42 hospitals, 100 primary care locations, 2,300 physicians, and over 55,000 pharmacy locations. In September 2000, the Plan formally changed its name from Michigan HMO Plans, Inc. to OmniCare Health Plan.

OmniCare Plus, the Plan's point-of-service product, allows its members the choice of using either "in-network" health care providers or going "out-of-network" to fulfill health care needs. When using in-network providers, a member receives health care services at little or no out-of-pocket cost. When using out-of-network providers, a member shares in the cost of the health care provided.

The Plan has a contract with the Michigan Department of Community Health (the Department) to provide health care services to Medicaid enrollees. This contract accounted for approximately 74% of the Plan's total revenues in 2001 and 67% in 2000.

The Department awarded the Plan a new contract for the period beginning October 1, 2000 and ending on September 30, 2002, with the potential for three one-year contract extensions. In February 2002, the Plan received an extension on the contract until September 30, 2003.

On July 30, 2001, the Ingham County Circuit Court of the State of Michigan granted a petition issued by the Commissioner of the Office of Financial and Insurance Services to place the Plan into rehabilitation. Rehabilitation allowed the Commissioner, as Rehabilitator, to take possession of all assets of the Plan and place the Plan under his control.

The Order of Rehabilitation suspended all powers of existing directors, officers, and managers of the Plan. The Order also required that United American Healthcare (UAHC) continue to provide management and administrative services that it is obligated to under the then-existing contract or any contract amendments to the Plan (see note 7).

(b) Basis of Presentation

The accompanying financial statements of the Plan have been prepared in accordance with the statutory accounting practices of the State of Michigan, Office of Financial and Insurance Services (OFIS).

Prescribed statutory accounting practices include a variety of publications of the National Association of Insurance Commissioners (NAIC), as well as state laws, regulations, and general administrative rules. Permitted statutory accounting practices encompass all accounting practices not so prescribed.

The accounting practices applied in the preparation of the statutory financial statements vary in some respects from accounting principles generally accepted in the United States of America. Departures from accounting principles generally accepted in the United States of America affecting the Plan principally relate to certain assets and liabilities which are reflected as assets or liabilities under accounting principles generally accepted in the United States of America but are excluded from assets and net worth or included as a component of net worth for statutory reporting purposes.

(c) Investments in Joint Venture and Subsidiary

Investments in joint venture and subsidiary are accounted for under the equity method.

(d) Cash and Cash Equivalents

Cash equivalents include investments which are liquid and mature in three months or less when purchased, excluding funds maintained under statutory requirements, and consist of investments in short-term obligations, including money market funds, certificates of deposit, U.S. Government obligations, and demand obligations.

(e) Investments

Short-term investments and marketable securities consist of investments in U.S. Government obligations. Short-term investments have maturity dates of one year or less at the purchase date. Additionally, $1.0 million is reserved pursuant to State of Michigan requirements and represents a contingency fund under an agreement with the Commissioner of OFIS. Such investments are carried at cost, less any valuation allowances and nonadmitted amounts.

(f) Capitation and Risk Sharing Reserve

Through August 31, 2000, the Plan had contracts with Individual Practice Associations (IPAs), which provided for withholdings from capitation payments to create a reserve for catastrophic claims incurred by the providers. Ultimate claims clearing in excess of reserves were shared 50% between providers and the Plan. The Plan's management implemented a plan to recover these amounts by additional withholding from capitation. These amounts were included in providers' accounts receivable at December 31, 2000. The contracts with IPAs provided for withholdings from capitation payments to create a reserve for risk sharing. The reserve was used to cover expenses incurred in the event of overutilization of hospitalization and other medical services. The amounts retained were payable when the Plan's management determined that the remaining funds were not required to cover related costs.

Effective September 1, 2000, the Plan renegotiated substantially all of its contracts with IPAs. Under its contracts, OmniCare pays for the delivery of primary care services through monthly capitation payments. Capitation payments to IPAs are subject to a 10% withhold, which is used to create a Withhold Fund. Withhold Funds are at risk of repayment, subject to the outcome of each IPA's referral experience measured against a risk pool (Referral Risk Pool) funded by the Health Plan. The Referral Risk Pools are funded by a contractually determined amount against which the IPA's referral services are charged. Each year, the Referral Risk Pool is evaluated for surplus or deficiency for each IPA. If the IPA's Referral Risk Pool is in a surplus, the IPA receives the Withhold Fund plus a bonus of 100% of the surplus (which is limited to 50% of the Withhold Fund). In the event of

a deficiency, the deficit is charged against the Withhold Fund. If the deficit is greater than the IPA's Withhold Fund, the Withhold Fund is retained by the Plan to offset the deficiency and the remainder of the deficit is the sole responsibility of the Plan. If the Withhold Fund is larger than the deficit, the deficit is retained from the Withhold Fund and the remainder of the Withhold Fund is paid to the IPA.

Effective August 1, 2001, the Plan entered into an agreement with the Detroit Medical Center (the DMC), a provider hospital, whereby the DMC assumes full risk for the inpatient, outpatient, and emergency room facility costs for specified Medicaid and commercial HMO members. Under this agreement, the DMC receives a per-member, per-month capitation for approximately 47,000, or 49% of the Plan's membership.

(g) Medical Claims Payable

Medical claims payable include the cost of services for which providers have submitted claims, as well as management's estimate of the cost of claims that have been incurred but not reported (IBNR). The cost of claims that have been incurred but not reported has been estimated by management based on relevant historical data and trends. Management believes that methodologies employed to estimate the claims liability are reasonable and the claims liability recorded is appropriate.

(h) Medical Services Expense

The Plan contracts with various health care providers for the provision of certain medical services to its members and generally compensates those providers on a capitated and fee-for-service basis.

(i) Premium Revenue

Membership contracts are negotiated on an annual basis, subject to cancellation by the employer group or the Plan upon 30 days' written notice. Premiums are due monthly and are recognized as revenue during the period in which the Plan is obligated to provide services to members. Amounts collected in advance of the due date are recorded as a deferred premium revenue liability.

(j) Excess of Loss Reinsurance

The Plan has an agreement with an insurance company to provide reinsurance for subscribers' claims. After a deductible of $0.2 million per member is reached, coverage under this agreement ranges between 80% and 90% of the excess eligible inpatient hospital services claims. The maximum annual reinsurance coverage for each member is $2.0 million.

Reinsurance premiums are reported as medical service expense, while the related reinsurance recoveries are reported as deductions from medical service expense.

(k) Tax Status

The Internal Revenue Service has ruled that the Plan qualifies as a tax-exempt entity under Section 501(c)(4) of the Internal Revenue Code (IRC). Once qualified, the Plan is required to operate in conformity with the IRC to maintain its qualification. Plan management is not aware of any course of action or series of events that have occurred that might adversely affect the Plan's qualified status.

(l) Use of Estimates

The presentation of the financial statements in conformity with statutory accounting principles requires management to make estimates and assumptions that affect reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported revenues and expenses during the reporting period. Actual results could differ from those estimates.

(m) Reclassifications

Certain 2000 amounts have been reclassified to conform with the 2001 presentation.

(2) Liquidity

As of December 31, 2001, the Plan had a net worth deficit of approximately $57.8 million. Additionally, significant losses from operations resulted in negative working capital of $57.0 million at December 31, 2001. The Plan having been placed into Rehabilitation was the result of the Plan's deteriorating financial condition. In August 2001, the OFIS Commissioner, in his role as Rehabilitator, appointed Deputy Rehabilitators to assess the Plan operationally and financially. The objective of the assessment was to develop a strategy to bring the Plan back to a healthy financial condition, with the result having been the development of a Rehabilitation Plan.

In March 2002, the Rehabilitation Plan was submitted to the Ingham County Circuit Court. The Rehabilitation Plan includes a restructuring of the liabilities existing at July 30, 2001 and, if approved as submitted, would increase statutory equity and working capital by $53.4 million and reduce cash by $17.5 million (see note 9).

The Plan's medical loss ratio (MLR) during 2001 was 99%, compared to 98% in 2000. Subsequent to the rehabilitation order, the Plan implemented contractual and operational changes, resulting in a decrease in medical and administrative costs. Changes having a significant impact included capitating hospital services for approximately 49% of the Plan's membership, improving coordination of benefits and medical management policies and procedures, and amending the management agreement with UAHC. Improvements in operational processes had the impact of reducing medical costs approximately $7 per member per month.

Prior to August 1, 2001, the Plan paid a management fee to UAHC equal to 14% of revenues. In August 2001, the fee paid to UAHC under the management agreement was revised to actual administrative costs plus 4%. The amended agreement reduced administrative costs from 14% of revenue to approximately 8%.

Under new regulations issued by OFIS in June 2000, HMOs are required to meet new net worth requirements on or before December 31, 2003. The requirement is the greater of $1.5 million, three months of uncovered expenditures, or 4% of annual subscription revenue. If a higher level is achieved prior to December 31, 2003, that level is required to be maintained. Furthermore, the NAIC introduced additional measurements of the minimum amount of capital appropriate for managed care organizations, known as Risk Based Capital (RBC), in 1998 to provide State Insurance Regulators additional standardized levels of action. Under the Rehabilitation Plan, the Plan is expected to achieve full statutory compliance by the end of 2006.

The Plan's commercial premium rates are expected to increase in 2002 by 15%-20% on average.

The Plan has initiated the selection of a new strategic information technology system intended to enhance the Plan's operations, support provider, member, and employer information requirements, and reduce the Plan's costs. The new system will include many features and capabilities that must now be performed manually. Activities that will be automated via the new system include enrollment, benefits management, premium billing, claims and encounter processing, medical management, case management, quality management, referral management, provider contracting, and Health Plan Employer Data and Information Set (HEDIS) reporting.

The effects of the contract changes, operational improvements, actions to be taken in the Rehabilitation Plan, and increased commercial rates are expected to reduce the Plan's MLR and administrative costs.

(3) Restatement of Prior Year

As a result of inaccurate actuarial assumptions used in the development of the prior year incurred but not reported claims liability, the medical claims payable as originally reported at December 31, 2000 were understated by $36.4 million. Further, due to the understatement of medical expenses, the Plan overstated management fees, which were conditioned upon achieving a certain medical loss ratio, by $3.8 million. To properly reflect the results of operations for the years ending December 31, 2001 and 2000, the Plan has received approval from OFIS to restate the prior year financial statements as a permitted practice. Accordingly, medical claims payable, due to affiliate, medical services expense, and management fee expense at and for the year ended December 31, 2000 have been restated. In addition, at December 31, 1999, the medical claims payable were understated by $29.5 million. The understatement has been recorded as a prior-period adjustment to the beginning net deficit for the year ended December 31, 2000. The statutory filings for 2000 and 2001 will be amended to reflect the above restatements.

(4) Health Care Receivables

The following table provides detail of the components of provider receivables at December 31, 2001 and 2000 (in thousands):

		2001	2000
Provider chargebacks	$	—	2,131
Duplicate payments		—	1,987
Provider overpayments		—	550
Maternity case rate receivable		529	1,860
Psychotropic drug reimbursements due		452	1,394
Medicaid capitation receivable		268	—
Pharmaceutical rebates		647	324
Federal Employee Health Benefits Plan		447	804
Provider advanced payments		2,734	—
	$	5,077	9,050

(5) Medical Liabilities

The following table provides a reconciliation of medical claims payable for the year ended December 31 (in thousands):

		2001	2000
Balance at beginning of year	$	57,119	53,784
Incurred loss related to prior year		—	—
Incurred loss related to current year		189,951	167,037
Total loss incurred		189,951	167,037
Paid claims related to current year		109,650	112,769
Paid claims related to prior year		45,995	45,933
Issuance of surplus note (note 6)		—	5,000
Total paid claims		155,645	163,702
Balance at end of year	$	91,425	57,119

(6) Surplus Notes

The following surplus notes are outstanding at December 31 (in thousands):

		2001	2000
United American Healthcare Corporation, June 30, 1998	$	4,600	4,600
United American Healthcare Corporation, April 13, 2000		7,700	7,700
Detroit Medical Center, November 29, 2000		5,000	5,000
	$	17,300	17,300

(Continued)

On April 13, 2000 and June 30, 1998, UAHC funded unsecured loans to the Plan, evidenced by surplus notes of $7.7 million and $4.6 million, respectively, to enable the Plan to meet its statutory net worth and working capital requirements at that time. Interest is at 8.5% and prime rate, respectively, and payments, if any, are subject to approval by the OFIS Commissioner. The $7.7 million surplus note consisted of conversion of $3.7 million of accrued and unpaid management fees and $4.0 million cash to the Plan.

In November 2000, the Plan converted medical claims payable owed to the DMC to a surplus note in the amount of $5.0 million. Interest is at 8.5%, and payments, if any, are subject to approval by the OFIS Commissioner.

Under the terms of the surplus notes, interest and principal payments are subject to approval by the OFIS Commissioner and shall be repaid only out of the statutory surplus earnings of the Plan. For 2001 and 2000, the Plan incurred no interest expense on these surplus notes.

(7) Related Party and Affiliated Transactions

The Plan has a management agreement with UAHC, effective through December 2005, whereby UAHC provides administrative services to the Plan. The Plan has the option to renew the agreement for a succeeding five-year period through the year 2010 at mutually satisfactory terms. Effective August 1, 2001, the management agreement was amended, whereby the Plan pays to UAHC actual administrative costs to manage the Plan plus 4%. Through July 30, 2001, management fee expense was computed as 14% of earned revenue. For the years ended December 31, 2001 and 2000, management fee expense aggregated $20.0 million and $18.7 million, respectively, under this agreement. At December 31, 2001, $2.6 million is due to the Plan from UAHC for overpayment of management fees. Management fees owed to UAHC by the Plan at December 31, 2000 are $0.9 million.

In addition, the Plan provides health care coverage to the employees of UAHC. For the years ending December 31, 2001 and 2000, premium revenue earned from UAHC was approximately $912,000 and $778,000, respectively.

The Plan is 100% owner of the outstanding common shares of its subsidiary, OmniCare TPA, Inc. During 2001, start-up and operational costs for OmniCare TPA, Inc. were paid by the Plan on behalf of OmniCare TPA, Inc. The amount paid, of less than $0.1 million, is included in due from affiliate on the balance sheet.

The Plan has a 60% interest in a joint venture with Blue Cross Blue Shield of Michigan, CasinoCare, LLC. The Plan offers its HMO product to employees of local casinos through this joint venture. The Plan's 60% ownership interest in this joint venture can vary between 50% and 60% each year based on the membership levels of each partner. At December 31, 2001 and 2000, CasinoCare owed the Plan $0.3 million and $0.4 million, respectively, for reimbursement of claims paid on the joint venture's behalf.

(Continued)

(8) Contingencies

The Plan is subject to extensive federal and state health care and insurance regulations designed primarily to protect enrollees, particularly with respect to government-sponsored enrollees. Such regulations govern many aspects of the Plan's business affairs and typically empower state agencies to review management agreements with health care plans for, among other things, reasonableness of charges. Among the other areas regulated by federal and state law are licensure requirements, premium rate increases, new product offerings, procedures for quality assurance, and the financial condition, including cash reserve requirements. Legislation mandating managed care for Medicaid recipients is often subject to change and may not initially be accompanied by administrative rules and guidelines. Changes in federal or state governmental regulation could affect the Plan's operations, cash flows, and business prospects. There can be no assurances that the Plan will maintain federal qualifications or state licensure.

On April 24, 2001, the Plan and the United States Office of Personnel Management (OPM) entered into a settlement agreement for amounts owed to OPM pursuant to an audit of the Federal Employees Health Benefit Plan (FEHBP) operations for the years 1988-1992 for certain overpayments made to the Plan in those years. Of the $1.8 million settlement, $0.2 million remains due and outstanding. In January 2002, the Plan received a draft audit report from OPM as a result of its audit of the Plan performed for the FEHBP for the years 1996-2000. In this draft report, the OPM has asserted that the Plan owes additional amounts for overpayments and lost investment income for those years. The Plan has recorded a contingent liability of $2.3 million for potential liabilities pursuant to this audit.

On July 30, 2001, the Ingham County Circuit Court of the State of Michigan granted a petition issued by the Commissioner of OFIS to place the Plan into rehabilitation. The continued operation of the Plan is contingent upon the Court's approval of a Plan of Rehabilitation. Failure to obtain such approval could result in the liquidation and dissolution of the Plan.

(9) Subsequent Events

On March 14, 2002, the Commissioner of OFIS, as Rehabilitator, filed a Plan of Rehabilitation with the Ingham County Circuit Court, which included restructuring the Plan's outstanding debt as of July 30, 2001. If approved, the proposed Rehabilitation Plan will be a final determination of the Plan's liabilities to its creditors at July 30, 2001 and will discharge the Plan's liability for all creditor claims, except as provided for in the Rehabilitation Plan approved by the Court. As submitted, the Plan of Rehabilitation would require the payout of $17.5 million in cash and the issuance of $27.5 million in surplus notes to discharge liabilities incurred prior to July 30, 2001 of $88.2 million, including $17.3 million in surplus notes. This transaction would have the impact of increasing statutory equity from a net deficit of $57.8 million as of December 31, 2001 to a net deficit of $4.4 million.